

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005051</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/27/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIANA UNIVERSITY HEALTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1701 N SENATE BLVD INDIANAPOLIS, IN 46206</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p><b>INITIAL COMMENTS</b></p> <p>This is a State hospital complaint investigation.</p> <p>Complaint #: IN00105334 Unsubstantiated; Lack of sufficient evidence.</p> <p>Dates of Survey: 03/27/2012</p> <p>Facility Number: 005051</p> <p>Surveyor: Albert Daeger, Medical Surveyor</p> <p>Indiana University Health is in compliance with 410 IAC 15-1.5-1, Dietetic services and 15-1.5-2, Infection control, Hospital Licensure Rules.</p> <p>QA: cloughlin 05/02/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1